DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

MENTAL HEALTH PARITY FOCUSED SURVEY

FINAL REPORT

Kaiser Foundation Health Plan, Inc.

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CONTENTS

EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Focused Survey of the Kaiser Foundation Health Plan, Inc. (the "Plan") in two parts. The Department surveyed the southern region of the Plan during May 2–5, 2005, and the northern region of the Plan during May 16–20, 2005. A "focused survey" assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"). In this case, the Focused Survey assessed compliance of the Plan's delivery of mental health services (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children).

Kaiser Foundation Health Plan, Inc. was the fifth of seven focused surveys completed between March and June 2005. Plans that were surveyed included Knox-Keene licensed full-service plans, and if applicable, specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full-service plan.

Health and Safety Code Section 1374.72, often referred to as the "**Parity Act**," requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and ensure the continuity and coordination of care provided to enrollees.

The Plan provides mental health services to 99.5 percent of its enrollees through The Permanente Medical Group (TPMG) and the Southern California Permanente Medical Group (SCPMG). (See Appendix B)

Background

The Kaiser Foundation Health Plan, Inc., or "Kaiser Permanente," as it is commonly known, consists of four principal organizations:

- The Kaiser Foundation Health Plan, Inc., which is a not-for-profit, public benefit California corporation that is a Knox-Keene-licensed full-service health plan;

- Kaiser Foundation Hospitals (KFH), which is a not-for-profit corporation that owns and operates hospitals that provide inpatient and outpatient services exclusively for Kaiser enrollees, with the exception of emergency services available to anyone who presents with an emergency. KFH contracts with academic and community-based hospitals for the provision of inpatient and outpatient services in parts of the service area where KFH hospitals cannot meet all the needs of the Kaiser enrollees. KFH also contracts with a number of skilled nursing facilities, home health agencies, and other ancillary services;

- The Permanent Medical Group (TPMG), which contracts exclusively with the Kaiser Foundation Health Plan, Inc. to provide professional services to Kaiser enrollees in northern California; and

- The Southern California Permanente Medical Group (SCPMG), which contracts exclusively with the Kaiser Foundation Health Plan, Inc. to provide professional services to Kaiser enrollees in southern California.

Because the two Permanente Medical Groups are separate and distinct and have different operations, the Department surveyed the southern and northern Kaiser Health Plan regions separately even though the Plan operates under one license statewide. The survey results are presented separately for each region.

Northern California Kaiser Permanente

Northern California Kaiser Permanente (NCKP) began in the 1930s as a prepaid, group practice, health care plan designed to care for Kaiser Industries' workers building the aqueducts and dams in the Mojave Desert and later the Grand Coulee Dam in Washington State.

Kaiser Foundation Health Plan, Inc., in Northern California began as a prepaid industrial health care program during World War II, serving thousands of workers at the Kaiser shipyards in Richmond. The program grew during the war to reach close to 200,000 members.

At the war's end, the KFHP was opened for community enrollment over a service area that included the cities of Richmond and Oakland. In 1946, the service area was expanded across the San Francisco Bay with the opening of medical offices in the city of San Francisco. The first members there were civilian workers from the Hunter's Point Naval Shipyard.

Hallmarks of early membership growth included enrollment of the International Longshoremen and Warehousemen Union under a 1950 collective bargaining agreement and a 1952 Labor Day election in which the United Steelworkers of America endorsed a union contract that added 10,000 new members. By 1953, one of every 10 San Franciscans was a Kaiser Permanente member.

In Modesto, the Plan has a mixed model of care delivery that includes both Permanente providers and a direct contract network called the Stanislaus Provider Network (SPN). Currently, the psychiatry clinic in Modesto is transitioning from a contracted arrangement with the Stanislaus County Department of Behavioral Health and Recovery Services (SBHC) to a model that includes Kaiser Permanente providers and a network of providers who are part of SBHC providing services non-urgent and urgent mental health and chemical dependency services. Members may self-refer to all programs, including a behavioral health assessment. An SPN primary care provider may contact the Kaiser Permanente-Modesto Behavioral Health Department for an assessment or consultation or referral for their patients. After normal business hours (8 A.M. to 5 P.M.) physician and member calls are routed to the After-Hours Call Center.

Southern California Kaiser Permanente

Southern California Kaiser Permanente (SCKP) started in 1954 with two medical center sites in Fontana and Los Angeles. Growth continued with the addition of medical centers in Harbor City (1959), Panorama City (1962), Bellflower (1965), San Diego (1966), West Los Angeles (1974), Anaheim (1979), Woodland Hills (1986), Riverside (1989), and Baldwin Park (1998).

The Bakersfield area medical offices were added in 1989, utilizing KFHP medical offices and SCPMG practitioners, but contracting with community hospitals for inpatient services. In February 1997, KFHP expanded operations into the Ventura and Coachella Valley geographic areas, contracting with four Affiliated Provider Groups: Buenaventura Medical Group and Seaview IPA in Ventura County and Desert Medical Group and Oasis IPA in Coachella Valley. In these two new areas, care is provided through affiliated hospitals and other facilities contracted by KFH or by the Affiliated Provider Groups. Affiliated Provider Groups, their practitioners, and affiliated facilities in the new areas are collectively referred to as the Affiliated Network Providers.

Health care services are provided in 14 geographic areas within KPSC. Of these 14 areas, 12 medical centers are managed by KPSC senior managers and physicians collectively known as the Medical Center Administrative Team (MCAT). The remaining two geographic areas are western Ventura County and the Coachella Valley, which are served by the Affiliated Network Providers.

The 12 medical centers are grouped into seven Service Areas. The MCATs from each of the medical centers within the Service Areas and the KFHP Service Area Manager are known as the Service Area Administrative Team. The Service Areas were created in 1994 to encourage the sharing of resources among Medical Centers within the Service Area to more efficiently and effectively meet the needs of the membership.

Survey Results

As part of the Focused Survey, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act: **Access and Availability of Services, Continuity and Coordination of Care, Utilization Management,** and **Delegation Management**.

Please refer to Section III for a detailed discussion of the deficiencies, the Department's findings, required corrective actions, the Plan's response and compliance efforts, and the Department's final determination regarding the status of the deficiencies.

Northern California Kaiser Permanente

The Department identified three compliance deficiencies in the Plan's implementation of and compliance with Section 1374.72 (see Section III, Table 1). The Plan has implemented corrective actions for these deficiencies. The Plan has corrected one of these deficiencies. One deficiency in the area of Access and Availability of Services and one deficiency in the area of Utilization Management/Benefit Coverage remain uncorrected at the time of this Final Report and both require Remedial Actions.

Southern California Kaiser Permanente

The Department identified three deficiencies in the Plan's implementation of and compliance with Section 1374.72 (see Section III, Table 4). The Plan has implemented corrective actions for these deficiencies. The Plan has corrected two of these deficiencies. One deficiency in the area of Utilization Management / Benefit Coverage remains uncorrected at the time of this Final Report and requires a Remedial Action.

SECTION I. FOCUSED SURVEY BACKGROUND

The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys ("Plan Surveys") conduct onsite medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full-service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed Plan Surveys to design focused surveys to review health plan compliance with enacted mental health parity laws. The project began in November 2004 and includes three phases:

(1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;
(2) Operations phase, included survey tool development and scheduling of the surveys; and
(3) Conduct the surveys.

The Department supports continued discussions with stakeholders and will receive comments and suggestions throughout the project.

The purpose behind the focused surveys was to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

The Focused Survey Approach

Focused surveys give the Department the ability to swiftly respond to potential serious health plan problems, concerns, or questions raised by consumers, legislators or other Department divisions on a particular issue. Focused surveys could include assessment of compliance with newly enacted legislation such as the Parity Act or specific applications such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal routine medical survey process, this focused survey approach allows a more detailed look at application and compliance.

SECTION II. SCOPE OF WORK

The subject of this Focused Survey is Health and Safety Code Section 1374. 72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plans are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act:

- **Access and Availability of Services** – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, whether the Plan clearly communicates those terms and conditions to enrollees, and whether the Plan has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.

- **Continuity and Coordination of Care** – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.

- **Utilization Management / Benefit Coverage** – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.

- **Delegation Management** – when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies on July 5, 2005. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan (CAP) for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

NORTHERN CALIFORNIA KAISER PERMANENTE

Tables 1 below lists deficiencies identified during the Focused Survey at the Plan's Northern Division.

TABLE 1: DEFICIENCIES

Northern California Kaiser Permanente

#	SUMMARY OF DEFICIENCIES	Status
A. ACCESS AND AVAILABILITY OF SERVICES		
1	**The Plan does not ensure that enrollees have timely access and ready referral to routine mental health services appointments for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code Section 1374.72.** [Rule 1300.74.72(f) and Rule 1300.67.2(f)]	Not Corrected **Remedial Action**
B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE		
2	**The Plan does not consistently provide the name and direct phone number of the denying health care professional in the denial letter sent to the requesting mental health professional.** [Section 1367.01(h)(4)]	Corrected
3	**The Plan incorrectly and inappropriately denies payment for emergency claims.** [Section 1371.4(b) and (c)]	Not Corrected **Remedial Action**

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan does not ensure that enrollees have timely access and ready referral to routine mental health services appointments for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72. [Rule 1300.74.72(f) and Rule 1300.67.2(f)]

Documents Reviewed:

- Best Practices and Action Plan to Improve Access Performance for Non-Urgent Initial Mental Health Appointment Summary – 2005
- Kaiser Permanente Northern California Psychiatry Services 2003 Q4 – 2004 Q4 (Behavioral Health Report Card)
- Psychiatry Coordinating Committee minutes for 2/9/05
- Quality Oversight Committee Executive Support Team minutes for 4/21/04, 7/21/04, and 4/20/05
- Medical Center Action Plans to Improve Access Performance for Non-Urgent Initial Mental Health Appointments – Summary
- Medical Center Action Plans to Improve Access Performance for Non-Urgent Initial Mental Health Appointments – Detail

Department Findings: The Plan has established an internal performance standard requiring that at least 90 percent of its routine appointments be seen within two weeks. Each quarter the Plan measures appointment availability separately for mental health (MH) and chemical dependency (CD). The most recent measurement (fourth quarter 2004) of its non-urgent initial visits (booked-to-seen date) showed an overall regional compliance rate of 61 percent for MH. Rates for individual facilities ranged from 29 percent in San Rafael to 96 percent in Fresno. For non-urgent return visits *(*seen-to-seen date), the Plan showed an overall compliance rate of 47 percent for MH. Rates for individual facilities ranged from 30 percent in Vacaville to 84 percent in Richmond.

The Department noted that the Plan conducts an initial assessment process prior to scheduling appointments to assure that those enrollees in need of emergent or urgent services receive them in a timely manner:

- Enrollees may visit clinics on a walk-in basis and receive an initial assessment with a clinician during that visit.
- Enrollees calling to make initial appointments receive a return call from a clinician (or immediately speak with a clinician in emergency situations), who performs a phone assessment.

This initial assessment process helps to match the enrollee with the appropriate therapist/program to meet that enrollee's needs.

The Department called a sample of 14 Plan facilities to confirm routine appointment availability within the two-week standard. Facility staff stated that an intake coordinator (clinician) could call back to do the initial assessment within 24 hours in 12 facilities. In two facilities, staff stated that the call could take up to two days. Staff at two facilities stated that routine appointments could be scheduled within two to four weeks and staff at one facility reported one to three weeks. The remaining facilities could schedule routine appointments within the two-week standard. All of the facilities emphasized that immediate care could be provided for emergencies and that urgent appointments could be scheduled within one day.

Plan staff stated that they had already identified routine appointment availability as opportunity for improvement prior to the Department's visit and had begun to address the issue. The Plan

has begun collecting data on its routine appointment availability, has identified those facilities that do not fully meet the standard, has identified "best practices" (i.e., successful strategies for addressing the issue), has shared those best practices with its individual clinics, and has begun implementation of appropriate corrective actions. The Plan intends to update its corrective action plan based on the results of the *Regional Psychiatry Services Annual Operational Survey 2005*, which was in progress at the time of this focused survey.

While the Plan addresses the issue regarding urgent and emergent appointment availability, ensuring that enrollees requesting services are promptly screened and that those with emergency and urgent needs are served immediately or within one day as appropriate, it has not however demonstrated that it has fully addressed the issue of inadequate access to routine appointments.

Implications: It is essential that those enrollees that do not have an emergency or urgent need receive timely appointments in order to initiate effective treatment, prevent possible exacerbation of conditions/issues, and promote enrollee satisfaction.

Corrective Actions: The Plan shall submit documented evidence that it has affectively addressed the issue of inadequate access to routine appointments including, but not limited to, its updated corrective action plan and the results of the most current quarterly re-measurement of appointment availability.

Plan's Compliance Effort: The Plan stated that it has taken the following actions to address the issue of inadequate access to routine/non-urgent appointments.

- The Regional Psychiatry Services Operational surveys for 2005 were completed in July 2005. The results are currently being complied and data collated for the annual report.

- In July 2005, facilities with a compliance rate below the established standard (90 percent) were requested to review their current corrective action plans (CAPs), determine what if any further actions need to be taken, revise the CAPs, and provide the time frames in which incremental change would be expected. In August 2005, the Regional Chief of Psychiatry and the Regional Director of Inpatient Psychiatry/Utilization received the CAPS, which are currently under review. Initial assessment notes that most facilities expect incremental change to occur in fourth quarter 2005.

- To ensure that the individual facilities as well as the regional directors are able to determine whether their CAPs are effective, appointment availability data will be reported on a monthly basis beginning in August 2005. Further corrective actions may be required if incremental change is not noted.

- Appointment availability data will be reported to the Psychiatry Coordinating Committee and Behavioral Health Quality Improvement Committee as appropriate.

The Plan submitted the document Appointment availability data - Psychiatry Services 2004 Q1–2005 Q1.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that while the Plan has initiated appropriate corrective actions to address the deficiency, it has not had sufficient time within the 45-day response period to complete all of its proposed corrective actions and to demonstrate the effectiveness of those actions.

REMEDIAL ACTION: Within 60 days of receiving this Final Report, the Plan is to provide the Department with updated appointment availability data, facility corrective action plans, committee minutes reflecting committee discussion on the issues, and any additional corrective actions implemented as a result of those discussions.

Once the review is complete, the Department will inform the Plan of any further action to be taken to fully correct this deficiency.

B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE

Deficiency 2: The Plan does not consistently provide the name and direct phone number of the denying health care professional in the denial letter sent to the requesting mental health professional. [Section 1367.01(h)(4)]

Documents Reviewed:
Eleven medical necessity denial files for the period May 2004–April 2005.

Department Findings: TPMG does not generate a large number of medical necessity denials, regardless of diagnosis. TPMG physicians and physicians with whom TPMG contracts for the provision of services make decisions about whether a covered service is medically necessary. In case of disagreement, the enrollee may file a grievance. Prior authorization and concurrent review, as applicable, are required only for services provided by out-of-Plan providers and solid organ transplants, durable medical equipment, prosthetics and orthotics, home health care, and bariatric surgery.

The Department reviewed 11 medical necessity denial files. In three denial letters, both the name and direct phone number of the denying health care professional were provided. In five denial letters, the name of the denying health care professional was provided, but the direct phone number was not given. In three files neither the name nor phone number of the denying health care professional was provided. These results are shown in Table 2.

Notably, all of the denial files document the conversation and the resolution of issues in which the denying physician spoke with the requesting mental health professional, even if the two professionals did not agree on the course of treatment. During the Department's onsite visit, TPMG presented two newly developed denial cover letters, one for e-mail and the other for

regular mail, to be sent to the requesting health care professional. Both templates include the name and direct phone number of the denying health care professional.

TABLE 2: MEDICAL NECESSITY DENIALS

Northern California Kaiser Permanente

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Medical Necessity Denials	11	The denial letter sent to the requesting provider must include the printed name and direct telephone number of the health professional who made the denial decision.	3	8

Implications: The absence of the name and telephone number of the mental health professional making the denial decision in the denial letter is a significant barrier to the requesting provider's ability to contact the decision-maker expeditiously to discuss the decision.

Corrective Action: The Plan shall submit evidence that it has implemented a system to ensure that the printed name and direct telephone number of the person making the denial decision is communicated to the requesting provider with the denial decision.

Plan's Compliance Effort: The Plan stated that corrective action was initiated to address this deficiency immediately following the survey findings, and implemented changes in August 2005. All requesting providers are notified of denials by either e-mail (The Permanente Medical Group physicians) or fax (contracted physicians). The changes are noted below.

- In those instances when the requesting physician is notified of a denial determination via fax, the cover sheet that accompanies the faxed denial letter will include the name and phone number of the physician making the determination and a notification to provide this information to the requesting physician.

- In those instances when the requesting physician is notified via e-mail, the e-mail template used includes the name and phone number of the physician making the determination.

- The Plan will include monitoring this practice in the quarterly audits of denial letters. The audit findings and any associated request for corrective action will be reported to the Regional Resource Management Committee.

The Plan submitted the following documents:

- Sample of fax cover letter
- Sample of e-mail template

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has appropriately revised its processes to ensure that the name and phone number of the physician making the determination is communicated to the requesting provider in cases of denials as evidenced by the Plan's provision of sample communications.

Deficiency 3: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4]

Documents Reviewed: Emergency service claims from March 2004–March 2005.

Department Findings: The Department reviewed a combined total of 54 ER claims (38 from nonparticipating providers and 16 from participating providers) from Kaiser South and North divisions. Twelve of the 38 nonparticipating providers' claims were from county facilities. The Department's findings from the northern division are summarized in Table 3 below:

TABLE 3: EMERGENCY ROOM (ER) CLAIMS DENIALS

Northern California Kaiser Permanente

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Par ER Claims	6	Appropriate denial	5	1
Non-Par ER Claims	17	Appropriate denial	12	5
County Facility (Non-Par)	3	Appropriate denial	0	3
Total no. of claims	23			

The northern and southern regions share common policies for processing emergency service claims, which are as follows:

- Automatic Payment: The Plan automatically pays claims if:
  - It meets Plan's definition of an emergency service. Plan defines emergency care as care needed immediately because of sudden injury or illness; the time required to reach Kaiser Permanente facility would mean risk or permanent damage to the patient's health; and transfer to a Kaiser Permanente facility is precluded because of serious risk to the patient's health or is unreasonable due to the distance involved and the nature of the patient's condition;

  - It meets prudent layperson rule;
  - The choice of the transport or facility is beyond the member's control and/or the member's immediate family; and
  - It contains emergency codes such as 5150 or 5850;
  - The out of area care obtained from a non-Kaiser provider or facility were urgent or emergent in nature.
- Denial: Plan denies ER claims that do not meet medical necessity and the criteria for emergent care.
- Suspend: Plan suspends or "pends" claims for additional medical documentation. The examiner shall attempt to collect the information by sending up to two letters of request before s/he closes the claim for nonsubmission of medical records.
- Medical Review: Upon initial determination that a complete claim may not meet emergency criteria as noted above, the claim is forwarded to the Medical Director or Associate Director to review for medical necessity.

The Department found that northern region denied six claims inappropriately. Specifically:

- Three claims were forwarded to another claims unit within Kaiser for processing; however, the letter to the enrollee stated: "Based on the information submitted, it appears this claim/bill is payable as an authorized referral. We are forwarding this bill to the appropriate Kaiser facility who authorized the care for processing. You are responsible for payment of this denied charge." Plan staff conceded that the language in the letter was confusing to the enrollee and explained further that the claim was only forwarded to another unit but not denied.
- Two ER claims from the county were denied because the services rendered were "routine" services. Discussion with Plan staff revealed that the examiners in these cases did not correctly recognize the emergency code (53) used by the provider to indicate place of service. Code 53, per Medicare, is a facility that provides "24 hour a day emergency care services" in addition to psychosocial outpatient services. Plan staff acknowledged that they had overlooked the place of service codes, and that if they had followed their guidelines, they would have requested medical records and review for medical necessity.
- One county claim was denied despite the presence of medical records indicating code 5150 for all dates and places of service billed, which according to Plan policy, should have been paid automatically.

Shortly after discovery of the above errors during this parity claim audit, all of the above three county claims were submitted to medical review and eventually paid.

Implications: Incorrect denial of payment for health care services to which enrollees are entitled breaches the agreement between the enrollee and the plan for covered services, creates a barrier to future services based on previously denied payments, and results in providers inappropriately billing enrollees for these services.

Corrective Action:

(1) The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures.

(2) Specific Audit criteria shall include, but not be limited to:
   a. Total number and percent of ER claims that qualified for automatic payment
   b. Total number and percent of ER claims that qualified for and were automatically paid
   c. Total number and percent of ER claims referred for medical review
   d. Accuracy of medical review determination, based on statutory requirements

(3) Files selected for audit should include appealed cases as well as initial determinations.

(4) File sampling method should be proportional to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20 percent of the Plan's total ER claims, then 20 percent of the ER claims selected for audit should be from county facilities.

(5) The Plan shall establish an implementation date for the audit program, which should not be later than two months from the date of this Preliminary Report, and include the implementation date in its response to this Preliminary Report. Audit results should be reported to the Department within a reasonable time frame after the first three and six months of the implementation date.

Plan's Compliance Effort: The Plan stated that:

- The Routing Matrix used by examiners in making decisions regarding what should be sent for clinical review will be revised to include claims with a Place of Service 53 and a CPT E&M code. Examiners will receive training on the routing matrix change, and review routing criteria related to claims with Revenue codes 450–459 and 510 by the first week of September 2005.

- A statewide audit program will be implemented by the end of September 2005. The audit findings will be sent to the DMHC for two consecutive quarters following implementation. The initial audit will be conducted for the period of 9/15/05 to 10/15/05. The results will be reported by October 30, 2005.

- The audit will address the following specific criteria: total number and percent of ER claims that qualified for automatic payment and were automatically paid, as well as the total number and percent of ER claims referred for medical review and accuracy of medical review determination, based on statutory requirements. The audit universe will include both paid and denied claims with either a revenue code of 450–459, 510, and a diagnosis code indicative of a mental health related condition, or a Place of Service 53. It will include appealed claims as well as those with an initial determination. Selected files will be in proportion to the percentage of claims received from different facility types.

- The audit results will be tracked, trended, and reported to Senior Management as part of the Regulatory Compliance Metrics Report on a quarterly basis and monthly at the California Claims Administration Compliance meeting.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that while the Plan has initiated appropriate corrective actions to address the deficiency, it has not had sufficient time within the 45-day response period to complete all of its proposed corrective actions and to demonstrate the effectiveness of those actions.

REMEDIAL ACTION: The Plan's findings from the statewide audit program for the first of the two consecutive quarters, as referenced above by the Plan, have not been received by the Department as of the date this Final Parity Report.

Within 60 days of receiving this Final Report, the Plan is to provide the Department with both quarters' findings and actions taken. Once the review is complete, the Department will inform the Plan of any further action to be taken to fully correct this deficiency.

SOUTHERN CALIFORNIA KAISER PERMANENTE

Tables 4 below lists deficiencies identified during the Focused Survey at the Plan's Southern Division.

TABLE 4: DEFICIENCIES

Southern California Kaiser Permanente

#	SUMMARY OF DEFICIENCIES	Status
A. UTILIZATION MANAGEMENT/BENEFIT COVERAGE		
1	**The Plan does not clearly and concisely describe the clinical reasons and clinical criteria used in making medical necessity denial determinations in the denial letters sent to enrollees and providers.** [Section 1367.01(h)(4)]	Corrected
2	**In its benefit denial notifications, the Plan does not provide the provisions of the Evidence of Coverage (EOC) or benefit contract that excludes the coverage.** [Section 1368(a)(5)]	Corrected
3	**The Plan incorrectly and inappropriately denies payment for emergency claims.** [Section 1371.4]	Not Corrected **Remedial Action**

The following details the Department's preliminary findings, the Plan's corrective actions, and the Department's findings concerning the Plan's compliance efforts.

A. UTILIZATION MANAGEMENT

Deficiency 1: The Plan does not clearly and concisely describe the clinical reasons and clinical criteria used in making medical necessity denial determinations in the denial letters sent to enrollees and providers. [Section 1367.01(h)(4)]

Documents Reviewed: Two medical necessity denial files for the period March 2004–April 2005.

Department Findings: Like TPMG, SCPMG does not generate a large number of medical necessity denials, regardless of diagnosis, because the treating provider makes the decision of whether a service is medically necessary. Referral within the KPSC system is done without obtaining prior approval.

The Department reviewed two medical necessity utilization management denial files that constituted the total number of medical necessity denials for the period March 2004–April 2005. One of the denials was issued by the SCPMG and the other was issued by a Delegate, Buenaventura Medical Group. Both the denial notification letters to the enrollee and to the requesting provider did not contain a description of the criteria or guidelines used to make or the clinical reasons for the decision. In one file, SCPMG's reasons for denial were "services are no longer medically necessary" and "care can be safely administered at a non-acute level, such as outpatient services." In the second file, the Delegate denied a psychiatrist's request for medication management sessions after a bipolar patient had not been seen for a year and stated that the patient's primary care physician could manage the care. The Delegate did not describe the clinical reasons for this decision. These results were reviewed with the Plan staff, who agreed with the Department's finding.

TABLE 5: MEDICAL NECESSITY DENIALS

Southern California Kaiser Permanente

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Medical Necessity Denials	2	The medical necessity denial letter to the enrollee and provider must contain a description of the criteria or guidelines used and the clinical reasons for the decisions.	0	2

Implications: When the Plan or Delegate does not describe the UM criteria used to make a medical necessity decision and the clinical reasons for the decision, the decision may appear to be arbitrary and capricious to both the enrollee and the requesting provider. Also, when this

information is not provided, neither the enrollee nor the provider acting on behalf of the enrollee has sufficient information to decide whether to appeal the decision.

Corrective Action: The Plan shall provide documented evidence that medical necessity denial notifications from both the Plan and its Delegates cite the UM criteria used and clearly and concisely state the clinical reasons for making the specific determination.

Plan's Compliance Effort: Utilizing the most current ICE Commercial Pre-Service Denial Notice (PSDN) template, the Plan developed two templates, medical necessity and benefit, for use by Buenaventura Medical Group. Each letter contains revised language that clearly informs members of the reasons for denials based on either medical necessity or benefit, respectively.

- Medical necessity denials will continue to require review and determination by the Utilization Management physician, and denial letters including the physician's clinical rationale and clinical criteria, if used, to make the denial determination.
- The Plan will provide training to BMG utilization staff by 8/20/05 on the new templates, including a sample of both the medical necessity and benefit denial using inserts from the benefit denial grid.
- The Plan will review BMG's compliance with these changes in its quarterly audits of denial letters. Compliance is expected at 95 percent or action plans are required.

The Plan submitted the following documents:

- Medical necessity denial letter
- Benefit denial letter
- Outside referral denial insert

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has developed appropriate template letters that include provision for a description of the clinical reasons and clinical criteria used in making medical necessity denial determinations. The Plan will also conduct training and incorporate it into its quarterly audits of denial letters to ensure ongoing compliance. The Department waived its typical requirement of a sample of denial communications as further evidence of the effectiveness of these corrective actions because a reasonable sample could not be produced from the low number of annual denials issued by the Plan.

Deficiency 2: In its benefit denial notifications, the Plan does not provide the provisions of the Evidence of Coverage (EOC) or benefit contract that excludes the coverage. [Section 1368(a)(5)]

Documents Reviewed: Twenty-nine benefit denials from the period March 2004–March 2005, of which nine were from Buenaventura Medical Group (BMG), one of four SCPMG delegates

Department Findings: The Department reviewed a total of 29 benefit denial files, three for children and 26 for adults. Nine were BMG files and 20 were SCPMG files. In 11 of the 29 files, the denial letter did not describe the provisions in the EOC that exclude the requested service. The most common error occurred in eight of the BMG denial letters, which were based on a standardized denial letter template developed by the Industry Collaborative Effort (ICE).

The language used in these letters had the following issues:

- When referring to a denial of a request for out-of-network services because the requested service was available within BMG, the letter stated: "Please refer to your EOC for more information. This determination was made in accordance with the terms and conditions of your EOC under the sections that describe the coverage and limitations for mental health services." However, this section of the Plan EOC does not describe the restrictions on out-of-network services.

- The language in the letter is ambiguous regarding whether BMG is making a medical necessity denial or a benefit coverage denial. For example, the letter states, "In reaching this decision, our physician reviewer applied the following clinical decision-making criteria: Guidelines established by our medical group. Please refer to your EOC for more information. Or you may obtain a free copy of the actual EOC benefit provision guideline, protocol or other similar criterion on which the denial decision was based by calling our office at …."

The Department reviewed these findings with Plan staff who believed that the Department had approved the ICE letter templates and therefore should not find any deficiencies with them. However, the Plan did not provide any Department documents that substantiated such approval.

TABLE 6: BENEFIT DENIALS

Southern California Kaiser Permanente

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Benefit Denials	29	Benefit denial letters clearly and concisely describe the provisions of the Evidence of Coverage	11	18

Implications: Poorly written and inaccurate benefit denial letters do not afford enrollees and their providers full and fair disclosure of the reasons that the requested service was denied. Specifically, when denial letters do not clearly distinguish between medical necessity denials and benefit denials, enrollees and providers do not understand the basis of the denial and whether an opportunity is available to file an appeal or request an independent medical review (IMR). When benefit denial letters do not direct enrollees to the appropriate section of the EOC, enrollees are not able to find and understand the rules that govern their participation in the health plan.

Corrective Actions: The Plan shall provide documented evidence that the BMG benefit denial letter templates have been corrected to:

- Distinguish clearly between a medical necessity and a benefit denial letter; and

- Accurately refer to the section of the EOC or contract that excludes the requested service or describes the conditions of participation (e.g., services must be received through the existing network) that were not met.

The Plan shall also provide evidence that the BMG has implemented the revised denial letter templates.

Plan's Compliance Effort: The Plan stated that, utilizing the most current ICE Commercial Pre-Service Denial Notice (PSDN) template, it developed two templates, medical necessity and benefit, for use by Buenaventura Medical Group. The Plan revised both letters to clearly inform members of the rationale for medical necessity and benefit denials, respectively, and also:

- Developed benefit denial reason inserts with relevant evidence of coverage (EOC) language, created a grid for reference, and provided it to Buena Ventura Medical Group to use in the benefit denial templates;

- By the end of September 2005 will provide training to BMG utilization staff on the new templates, including a sample of both the medical necessity and benefit denial using inserts from the benefit denial grid; and

- Will review BMG's compliance with these changes in its quarterly audits of denial letters and require action plans if compliance falls below 95 percent.

The Plan submitted a copy of the Outside Referral Denial insert.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has developed appropriate template letters and has developed a list of Outside Referral Denial inserts to provide appropriate references to the EOC or contract. The Plan has also proposed to conduct training and to incorporate this issue into its quarterly audits of denial letters to ensure continued compliance.

Deficiency 3: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4]

Documents Reviewed: Emergency service claims from March 2004–March 2005.

Department Findings: The Department found that the southern region did not pay or deny claims from nonparticipating (non-par) providers in accordance with its policies. Eleven of the 21 non-par claims were inappropriately denied, eight of which were from county facilities. Specific findings were as follows:

- Six claims (five county and one private) were denied for lack of medical documentation with no evidence of the examiner requesting additional information. Plan staff conceded that no letter or explanation of benefits (EOB) was sent to the provider requesting the specific missing documentation.

- Three county claims were denied for lack of documentation despite the attachment of medical records showing codes 5150 or 5855, which Plan policy states as automatically payable.

- Two private claims were denied by medical review for not meeting the emergency criteria. While the Plan had appropriate reason to deny the claims, it did not send any denial letters to the members notifying them of the reasons for denial. Plan staff conceded that the letters were not generated and cited examiner error.

Table 7 summarizes the Department's findings.

TABLE 7: EMERGENCY ROOM (ER) CLAIMS DENIALS

Southern California Kaiser Permanente

FILE TYPE	# OF FILES REVIEWED	CRITERIA	#COMPLIANT	#DEFICIENT
Par ER Claims	10	Appropriate denial	10	0
Non-Par ER Claims	21	Appropriate denial	10	11
County Facility	9	Appropriate denial	1	8
Total number of claims	31			

Implications: Incorrect denial of payment for health care services to which enrollees are entitled breaches the agreement between the enrollee and the plan for covered services, creates a barrier to future services based on previously denied payments, and results in providers inappropriately billing enrollees for these services.

Corrective Action:

(1) The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures.

(2) Specific Audit criteria shall include, but not be limited to:
   a. Total number and percent of ER claims that qualified for automatic payment

b. Total number and percent of ER claims that qualified for payment and were automatically paid
c. Total number and percent of ER claims referred for medical review
d. Accuracy of medical review determination based on statutory requirements

(3) Files selected for audit should include appealed cases as well as initial determinations.

(4) File sampling method should be proportional to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20 percent of the Plan's total ER claims, then 20 percent of the ER claims selected for audit should be from county facilities.

(5) The Plan shall establish an implementation date for the audit program, which should not be later than two months from the date of this Preliminary Report, and include the implementation date in its response to this Preliminary Report. Audit results should be reported to the Department within a reasonable time frame after the first three and six months of the implementation date.

Plan's Compliance Effort: The Plan stated that it will:

- Revise the Routing Matrix used by examiners in making decisions regarding what should be sent for clinical review to include claims with a Place of Service 53 and a CPT E&M code. Examiners will receive training on the routing matrix change, and review routing criteria related to claims with Revenue codes 450–459 and 510 by the first week of September 2005.

- Implement a statewide audit program by the end of September 2005. The audit findings will be sent to the DMHC for two consecutive quarters following implementation. The initial audit will review the year from 9/15/05 to 10/15/05 and report the results by October 30, 2005.

- Address in the audit the total number and percent of ER claims that qualified for automatic payment and were automatically paid, and the total number and percent of ER claims referred for medical review and the accuracy of medical review determination based on statutory requirements. The audit universe will include both paid and denied claims with either a revenue code of 450–459, 510 and a diagnosis code indicative of a mental health related condition, or a Place of Service 53. It will include appealed claims as well as those with an initial determination. Selected files will be in proportion to the percentage of claims received from different facility types.

- The audit results will be tracked, trended, and reported to Senior Management as part of the Regulatory Compliance Metrics Report on a quarterly basis and monthly at the California Claims Administration Compliance meeting.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that although the Plan has initiated appropriate corrective actions to address the deficiency, it has not had sufficient time within the 45-day response period to complete all of its proposed corrective actions and to demonstrate the effectiveness of those actions.

REMEDIAL ACTION: The Plan's findings from the statewide audit program for the first of the two consecutive quarters, as referenced above by the Plan, have not been received by the Department as of the date of this Focused Survey Final Report.

Within 60 days of receiving this Final Report, the Plan is to provide the Department with both quarters' findings and actions taken. Once the review is complete, the Department will inform the Plan of any further action to be taken to fully correct this deficiency.

D. SURVEY CONCLUSIONS (BOTH REGIONS)

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

A P P E N D I X A

METHODOLOGY & PARAMETERS

A. Review Methodology

The Department conducted a Focused Survey of the Plan's southern region during May 2–5, 2005, at the Plan's offices in Pasadena, California, and a Focused Survey of the Plan's northern Region during May 16–19, 2005, at the Plan's offices in Oakland, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey of the Plan's northern region utilizing the clinical expertise of a psychiatrist and a licensed psychologist. The Department conducted the survey of the Plan's southern region utilizing the clinical expertise of a psychiatrist, a licensed psychologist, and a licensed clinical social worker.

Survey activities included the review of Plan documents, enrollee case files, and claims. The Surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 14 Plan facilities in the northern region and reviewed the appointment records of 15 Plan facilities in the southern region to assess appointment availability. Each survey activity is described in greater detail below.

Review of Plan documents: The Department reviewed a number of additional materials to assess various aspects of Plan compliance such as:

- Policies and procedures for all related activities
- Internal performance standards and performance reports
- Communications regarding benefits
  - Explanation of coverage
  - Explanation of benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits, and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities, and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

Review of utilization management and care management files: Prior to the onsite visit, the Department requested logs for a number of Plan activities such as utilization review and claims processing. From these logs the Department selected samples of case files for a comprehensive review that focused on measures such as appropriateness of denials of services and timeliness of decision-making. Plan staff participated in the review of utilization management files.

Because the Plan's policy is to fill all prescriptions written by Permanente physicians or Permanente-contracted physicians unless the requested medication is not FDA-approved or in case of questions about patient safety, the Department had no denials of non-formulary pharmaceuticals to review.

The mental health care managers are master's-prepared mental health clinicians who serve as the enrollee's primary therapist as well as care manager. The care management documentation is embedded in the enrollee's mental health medical record. The Department agreed with the Plan that it would not review the mental health medical records in order to preserve the confidentiality of enrollee-protected health information. Therefore, the Department chose to evaluate the care management system through structured interviews of care managers in which the care managers orally reviewed selected cases.

Table 8 below displays the categories of utilization management files reviewed and the sample sizes selected for both northern and southern California.

TABLE 8: FILES REVIEWED

BOTH REGIONS

CATEGORY OF FILE	SAMPLE SIZES	
	NORTH	SOUTH
Utilization Management - Medical Necessity Denials for Children with Autism or Seriously Emotionally Disturbed Children	5	1
Utilization Management - Medical Necessity Denials for Other Individuals	6	1
Utilization Management - Benefit Denials for Children with Autism or Seriously Emotionally Disturbed Children	3	2
Utilization Management - Benefit Denials for Other Individuals	2	27
Utilization Management - Denials of Non-Formulary Pharmaceuticals	None	None
Continuity and Coordination of Care – Case Management Files	None	None

Review of claims: Prior to the onsite visit, the Department requested claims listings from which it selected samples for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. Plan staff participated in the review of claims files. Table 9 below displays the categories of claims reviewed and the sample sizes selected.

TABLE 9: CLAIMS FILES REVIEWED

BOTH REGIONS

CATEGORY OF CLAIM	SAMPLE SIZE	
	NORTH	SOUTH
Claims for emergency services from nonparticipating providers	17	21
Claims for emergency services from participating providers	6	10

Interviews: The Department interviewed staff from the Plan, TPMG, SCPMG, and KFH to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims, and documents reviewed. Appendix C lists the individual officers and staff members interviewed, along with their respective titles, and Appendix D lists the Department's survey team members who conducted the interviews.

B. Utilization Management File Review Parameters

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses;
- Accuracy of case categorization (parity vs. nonparity);
- Decision rendered/action taken by plan (approval or denial);
- Adequacy of clinical information obtained to support decision-making;
- Documentation of rationale supporting the decision rendered;
- Accuracy of decision based upon statutory requirements; and
- Consistency between decision and communication sent to the affected practitioner/provider and member.

C. Claims Review Parameters

The parameters assessed during the review of claims included:

- Diagnoses;
- Accuracy of claim categorization (parity vs. nonparity; participating vs. nonparticipating; and emergency vs. nonemergency);
- Adequacy of administrative and clinical information obtained to support denial decision-making;
- Appropriateness of denial;
- Documentation of referral to medical review prior to denial decision rendered;
- Accuracy of documented denial reason based upon plan policies regarding claim processing;
- Accuracy of payment based on mandated parity benefits; and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee.

A P P E N D I X B

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

Tables 10 through 15 below summarize the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaires.

TABLE 10: PLAN PROFILE

NORTHERN CALIFORNIA KAISER PERMANENTE

Type of Plan	**Full Service Plan**	
Number of Enrollees Covered by Mental Health Parity as of December 31, 2004	**Product Lines**	**Enrollees**
	Kaiser Permanente Traditional Plan Commercial Group (51+ members)	2,083,502
	Kaiser Permanente Traditional Plan for Small Businesses Small Group – Commercial	348,991
	Kaiser Permanente Pacific Health Advantage Pac Advantage Small Group	26,177
	Kaiser Permanente Traditional Plan for Small Businesses Small Group – Cal Choice	18,503
	Kaiser Permanente Deductible Plan Small Group – Deductible Plan	1,498
	Kaiser Permanente Senior Advantage Medicare Advantage – Group	152,049
	Kaiser Permanente Senior Advantage Medicare Advantage - Individual	195,675
	Kaiser Permanente Medicare Cost Medicare Cost - Group	9,443
	Kaiser Permanente Medicare Cost Medicare Cost – Individual	2,803
	Kaiser Permanente Personal Advantage Commercial – Individual Plan	194,693

	Product Lines	Enrollees
Number of Enrollees Covered by Mental Health Parity as of December 31, 2004	Kaiser Permanente Individual Conversion Plan Individual Conversion Plan	32,080
	Kaiser Permanente HIPAA Individual Plan Individual HIPAA Plan	3,086
	Kaiser Permanente Deductible Plan Individual – Deductible Plan	3,677
	State Programs - Medi-Cal Medi-Cal Plans	54,116
	Kaiser Permanente STEPS Plan Dues Subsidy	12,399
	MRMIP	2,173
	KP Cares for Kids Child Health Plan	4,929
	Healthy Families Program Healthy Families	30,554
	Access for Infants and Mothers Program AIM	617
	Kaiser Permanente Insurance Corporation PPO/POS	1,166
	Total	**3,178,131**

Service Area(s) *(counties, in full or in part)*	The following counties are entirely within the service area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. The following counties are partially in the service area: Amador, El Dorado, Fresno, Kings, Madera, Mariposa, Napa, Placer, Santa Clara, Sonoma, Sutter, Tulare, Yolo, and Yuba. All of the products noted above, with the exception of the Kaiser Permanente Individual Conversion (KPIC) product, are offered throughout the service area. KPIC is only offered in the group market and with marketing leadership approval.

Plan Identification of Enrollees Eligible for Parity Services
Adults: The provider documents the enrollee's diagnosis in the treatment record and on the encounter coding form, which is linked to the patient's visit history in the applicable data system. The data system does not count visits containing parity diagnoses against the visit limit in the enrollee's benefit plan.
Seriously Emotionally Disturbed Children: The provider documents the enrollee's diagnosis in the treatment record and whether the enrollee meets the SED criteria in the medical record. The provider also records the diagnosis on the encounter form and checks the "SED" box on the form, which is linked to the patient's visit history in the applicable data system. The data system does not count SED visits against the visit limit in the enrollee's benefit plan. The Plan identifies Healthy Families SED enrollees in the same manner. According the Chair, Chiefs of Psychiatry, TPMG, providers generally do not refer Healthy Families children and adolescents to the county mental health systems for SED evaluation unless the enrollee has exhausted his/her inpatient benefit for the year and/or needs a service that is not a covered benefit. This includes long-term residential treatment, group home placement, day care, and foster care. Even after the Healthy Families SED enrollee's care is transferred to a county mental health program, the TPMG psychiatrist or pediatrician continues to provide medication management services.

TABLE 11: MENTAL HEALTH PROVIDER NETWORK

NORTHERN CALIFORNIA KAISER PERMANENTE

Practitioners Who Treat Adults	Number in the Network
Psychiatrists	310
Doctoral-level psychologists	509
Mental health nurse practitioners with furnishing numbers	27
Licensed Marriage and Family Therapists (LMFTs)	161
Licensed Clinical Social Workers (LCSWs)	406
Total	**1,413**

Practitioners Who Treat Children and Adolescents	Number in the Network
Psychiatrists	59
Doctoral-level psychologists	16
LMFTs	9
LCSWs	11
Total	**95**

Programs and Institutional Providers That Treat Adults	Number in the Network
Acute inpatient units—voluntary admissions	24 Contracted Hospitals
Acute inpatient units—involuntary admissions	24 Contracted Hospitals
Crisis treatment centers/programs	10 Contracted 23-Hour Programs 13 Contracted Short-term Residential Crisis Treatment Centers
Intensive outpatient treatment programs/partial hospitalization	25 Plan Intensive Outpatient Treatment Programs 13 Contracted Intensive Outpatient Treatment Programs
Residential treatment programs	Not a covered benefit
Eating disorder programs	3 Contracted Inpatient Eating Disorder Programs 1 Plan Outpatient Eating Disorder Program
Programs and Institutional Providers That Treat Children and Adolescents	**Number in the Network**
Acute inpatient units—voluntary admissions	10 Contracted Facilities
Acute inpatient units—involuntary admissions	10 Contracted Facilities
Crisis treatment centers/programs	9 Contracted 23-Hour Programs
Intensive outpatient treatment programs/partial hospitalization	3 Contracted Short-term Residential Crisis Treatment Centers
Residential treatment programs	Not a covered benefit
Eating disorder programs	3 Contracted Inpatient Eating Disorder Programs 1 Plan Intensive Outpatient Eating Disorder Program

TABLE 12: ACCESS AND AVAILABILITY STANDARDS

Northern California Kaiser Permanente

Availability Standards			
Type of Practitioner	**Ratio of Practitioners to Enrollees[1]**	**Geographic Availability**	**Percent of Open Practices**
Psychiatrists, psychologists, and master's-prepared therapists	The Plan does not have a standard. The actual ratio of behavioral health practitioners, including chemical dependency counselors, to enrollees as of December 2004 was 1:2936.3.	80% of members must live within 30 miles of a service location (i.e., a clinic or medical center) where outpatient behavioral health services are provided.	All TPMG psychiatry offices/clinics are open to new patients.

Appointment Availability Standards	
Type of Services	**Standard**
Non-Life-Threatening Emergency	The Plan includes non-life-threatening emergencies in the measurement of life-threatening emergencies, and patients are seen immediately.
Urgent – Initial Care	1 day
Initial Post-hospitalization Follow-up Visit	7 calendar days from discharge
Routine – Initial Visit	2 weeks

Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral Average Speed of Answer (Psychiatry After-Hours Call Center Data)	30 seconds
Triage and Referral Abandonment Rate (Psychiatry After-Hours Call Center Data)	5%
Appointment Call Center Average Speed of Answer	30 seconds
Appointment Call Center Abandonment Rate	5%
Member Services Average Speed of Answer	30 seconds
Member Services Abandonment Rate	3%

[1] NCKP does not have a standard for the ratio of practitioners to enrollees. For operational planning, NCKP evaluates multiple criteria to determine whether services are available to our members, including geographic availability, behavioral health inpatient satisfaction, enrollee member satisfaction, and physician satisfaction.

TABLE 13: PLAN PROFILE

Southern California Kaiser Permanente

Type of Plan	Full Service Plan	
Limited License Knox-Keene Plans and Medical Groups (i.e., delegates) with which SCPMG contracts for Provision of any Section 1374.72 Services as of December 2004	Organization	Enrollees
	Western Ventura	
	Buenaventura Medical Group	4,463
	Seaview IPA	8,867
	Coachella Valley	
	Desert Medical Group (part of Heritage Provider Network)[2]	2,733
	Oasis IPA (part of Heritage Provider Network)	15,331
	Total	31,394 (1%)
Number of Enrollees Covered by Mental Health Parity as of December 31, 2004	Product Line/Product	Number of Enrollees
	Kaiser Permanente Traditional Plan Commercial (51+ members)	2,146,192
	Kaiser Permanente Traditional Plan for Small Businesses Small Group – Commercial	276,294
	Kaiser Permanente Pacific Health Advantage Small Group – Pac Advantage	14,412
	Kaiser Traditional Plan for Small Businesses Small Group – Cal Choice	12,664
	Kaiser Permanente Deductible Plan Small Group – Deductible Plan	1,222
	Kaiser Permanente Personal Advantage Commercial – Individual Plan	153,500
	Kaiser Permanente Conversion Plan Individual – Conversion Plan	15,751
	Kaiser Permanente HIPAA Individual Plan Individual HIPAA Plan	1,757

[2] Heritage Provider Network, Inc., is a limited-license Knox-Keene full-service health plan.

	Product Line/Product	Number of Enrollees
Number of Enrollees Covered by Mental Health Parity as of December 31, 2004	Permanente Deductible Plan Individual – Deductible Plan Kaiser	3,947
	STEPS Dues Subsidy	6,948
	MRMIP	2,923
	KP Cares for Kids Child Health Plan	8,112
	Healthy Families	49,194
	Access for Mothers and Infants (AIM)	700
	Kaiser Permanente Insurance Company (KPIC) PPO/POS	3,885
	Total	3,057,520 (99%)
Service Area(s) *(counties, in full or in part)*	Orange and Los Angeles Counties (except zip code 90704) are entirely within the Plan's service area. Portions of Imperial, Kern, Riverside, San Bernardino, San Diego, and Ventura counties are also in the Plan's service area. All of the products noted above, with the exception of the Kaiser Permanente Individual Conversion (KPIC) product, are offered throughout the service area. KPIC is only offered in the group market and with marketing leadership approval.	

Plan Identification of Enrollees Eligible for Parity Services

Adults: The SCPMG mental health professional makes the diagnosis at the time of the enrollee's outpatient or inpatient visit. This information is held in the enrollee's paper medical record and the electronic patient information system. Visits are not tracked electronically against a benefit maximum.

Seriously Emotionally Disturbed Children (SED): SCPMG behavioral health providers assume that any child who needs mental health services for a prolonged period of time and/or needs inpatient mental health services is SED. Visits are not tracked electronically against a benefit maximum.

The Plan identifies Healthy Families SED enrollees in the same manner. According to the Chief of Psychiatry Services, Panorama City and Woodland Hills, who is a child psychiatrist, providers generally do not refer Healthy Families children and adolescents to the county mental health systems for SED evaluation unless the enrollee has exhausted his/her inpatient benefit for the year and/or needs a service that is not a covered benefit. This includes long-term residential treatment, group home placement, day care, and foster care. Even after the Healthy Families SED enrollee's care is transferred to a county mental health program, the SCPMG psychiatrist or pediatrician continues to provide medication management services.

TABLE 14: MENTAL HEALTH PROVIDER NETWORK

Southern California Kaiser Permanente

Practitioners that Treat Adults	Number in the Network
Psychiatrists	171.14
Doctoral-level psychologists	29.45
Mental health nurse practitioners with furnishing numbers	4.9
Other mental health nurses – Clinical Nurse Specialists, psychiatric registered nurses, Psych RN Case Managers, Psych Advice RNs, LVNs, Staff RNs	60.2
LMFTs and LCSWs	335.46
Total	**601.15**

Practitioners That Treat Children and Adolescents	Full-Time Equivalents in the Network
Psychiatrists – Child and Adolescent Fellowship	41.2
Doctoral-level psychologists	Included in the above figures
LMFTs and LCSWs	Included in the above figures
Total	**41.2**

Programs and Institutional Providers That Treat Adults	Full-Time Equivalents in the Network
Acute inpatient units—voluntary admissions	1 Plan Hospital 20 Contracted Hospitals
Acute inpatient units—involuntary admissions	1 Plan Hospital 16 Contracted Hospitals
Crisis treatment centers/programs	8 Contracted Short-term Residential Crisis Treatment Centers
Intensive outpatient treatment programs/partial hospitalization	5 Plan Intensive Outpatient Treatment Programs 1 Plan Partial Hospitalization Treatment Program 5 Contracted Intensive Outpatient Treatment Programs
Residential treatment programs	Not a covered benefit
Eating disorder programs	11 Outpatient Programs

Programs and Institutional Providers That Treat Children and Adolescents	Number in the Network
Acute inpatient units—voluntary admissions	12 Contracted Hospitals
Acute inpatient units—involuntary admissions	12 Contracted Hospitals
Crisis treatment centers/programs	8 Contracted Short-term Residential Crisis Treatment Centers
Intensive outpatient treatment programs/partial hospitalization	11 Plan Intensive Outpatient Treatment Programs 2 Contracted Intensive Outpatient Treatment Programs
Residential treatment programs	Not a covered benefit
Eating disorder programs	11 Plan Outpatient Programs

TABLE 15: ACCESS AND AVAILABILITY STANDARDS

Southern California Kaiser Permanente

Access Standards			
Type of Practitioner	**Ratio of Practitioners to Enrollees[3]**	**Geographic Availability**	**Percent of Open Practices**
Psychiatrists	The Plan does not have standards. The actual ratio, as of December 2004, is 0.05 psychiatrists per 1,000 enrollees.	80% of members must live within 15 miles or 30 minutes of a service location (i.e., a clinic or medical center) where outpatient behavioral health services are provided.	All SCPMG psychiatry offices/clinics are open to new patients
All other licensed mental health providers	The Plan does not have standards. The actual ratio, as of December 2004, is 0.128 therapists per 1,000 enrollees.		

[3]SCKP does not have standards for the ratio of practitioners to enrollees. For operational planning, KPSC evaluates multiple criteria to evaluate provider availability, including through satisfaction surveys that measure the satisfaction of patients using Psychiatry Department services with the location of services and the patient's ability to obtain services and evaluation of the geographic availability of behavioral health services.

Appointment Availability Standards	
Type of Services	**Standard**
Non-life-threatening Emergency	6 hours or less KPSC measures 1 hour or less for urgent conditions seen in the Emergency Department
Urgent – Initial Care	1 calendar day
Initial Post-hospitalization Follow-up Visit	7 calendar days from date of discharge
Routine – Initial Visit	14 calendar days
Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral Average Speed of Answer (Behavioral Healthcare Help Line Data)	30 seconds
Triage and Referral Abandonment Rate (Behavioral Healthcare Help Line Data)	5%
Appointment Call Center Average Speed of Answer	50 seconds
Appointment Call Center Abandonment Rate	5%

B. Overview of Programs

The paragraphs below present a brief overview for each region of the Plan's operations in each of the four program areas examined during the Department's focused survey.

NORTHERN CALIFORNIA KAISER PERMANENTE

OVERVIEW OF PROGRAMS

ACCESS AND AVAILABILITY

- Under the Plan's "open direct access" no prior authorization or approval is required. Therefore, most enrollees access behavioral health services by calling a clinic directly to request an appointment. The enrollee speaks with a clinician immediately, if indicated, or within 24 to 48 hours, depending upon the clinic. The clinician assesses the enrollee's needs, determines the appropriate clinician/program type, and provides the appointment booking at the time of the call.

- Any medical or ancillary service practitioner can refer the enrollee for services electronically through the e-consult system. The practitioner enters the request for consultation in the system, which automatically sends the request to the designated clinician. The clinician calls the enrollee within two days of receipt of the consult, assesses the enrollee's needs, and arranges an appointment. Visit information is entered into the same system. This allows the Psychiatry Department to monitor the time from the referral to the first appointment and from the first appointment to the second appointment.

- Plan mental health providers conduct an assessment of new patients, determine a diagnosis, and develop a clinically appropriate treatment plan. No preauthorization is required for services provided by TPMG providers or TPMG-contracted providers within the NCKP system. The TPMG utilization management unit provides preauthorization and concurrent reviews, if applicable, for out-of-Plan services.

- Enrollees may access emergency services in several ways: through the Psychiatry After-Hours Call Center (PACC); by going directly to a Plan hospital emergency room; by going to a non-Plan hospital emergency room; or by calling 911.

- The PACC answers enrollee calls when the medical clinics are closed on evenings, weekends, and holidays. The PACC is staffed by licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and psychiatric nurses and clinicians who assess the caller's needs and provide advice or arrange for immediate care.

- The majority of psychiatric services are provided by TPMG providers. However, KFH does not own or operate a psychiatric inpatient facility in northern California. Therefore, KFH contracts with non-Plan acute care inpatient facilities. TPMG psychiatrists have attending privileges at some of these hospitals. At others, TPMG

contracts with, and credentials, community psychiatrists to provide attending psychiatrist services.

- In Modesto, TPMC is transitioning from a contracted arrangement with the Stanislaus County Department of Behavioral Health and Recovery Services (SBHC) to a mixed-model using Plan and TPMC providers.

- Outpatient psychiatry services are provided through teams that cover Adult Psychiatry, Child Psychiatry, and Outpatient Chemical Dependency services. Crisis services are fully integrated with these teams. Clinic Departments of Psychiatry are staffed by licensed physicians, registered nurse practitioners, psychologists, social workers, marriage and family therapists, and certified alcohol and drug abuse counselors. Behavioral health clinicians work within the primary care clinics and link with the specialty mental health services in the Department of Psychiatry.

- Seventy-six percent of primary care practitioners said they were satisfied or very satisfied with referring patients to the primary care clinic-based behavioral health clinicians. This was one of the highest satisfaction ratings achieved on the 2004 survey for questions about satisfaction with processes and communication with BH.

- Enrollees that meet criteria for involuntary hospital admissions (5150 admissions) are evaluated in a Plan hospital Emergency Department, a contracted hospital Emergency Department or a clinic. If the enrollee is determined eligible for an involuntary hospital admission, the Plan arranges for transfer to a contracted psychiatric hospital for further evaluation and inpatient admission.

- The Plan does not routinely use community residential treatment facilities to treat eating disorders. Not only is residential treatment not a covered benefit for most enrollees, but also TPMG staff stated that they perceive that these facilities do not deal effectively with underlying issues and do not provide effective discharge planning, resulting in a return to previous behaviors and loss of weight upon return to the community. The Department of Psychiatry in each medical center has an Eating Disorders Champion responsible for the implementation of the TPMG operational guidelines for the Eating Disorders programs. The Plan provides the following levels of care:

  - Inpatient services for medical care and re-feeding, which is available at most KFH hospitals. The Plan is currently developing centers of excellence within the northern California KFH facilities;

  - Inpatient psychiatric care at contracted facilities;

  - Partial hospitalization programs;

  - An Eating Disorders Intensive Outpatient Program (EDIOP) in Sacramento (two more EDIOPs are in development); and

  - Outpatient services available at every medical center.

- The Plan has a Healthy Families Clinical Liaison for each Department of Psychiatry in each county to facilitate referrals and sharing of information.

- Two mental health benefit features improve access for individuals who do not have parity benefits in both the northern and southern regions:

  - The Plan does not count medication management visits against the enrollee's annual mental health visit limit and when mental health parity was implemented; and

  - The Plan lowered the co-payments for all mental health visits to the same levels as for medical visits.

UTILIZATION MANAGEMENT/ BENEFIT COVERAGE

- TPMG only preauthorizes bariatric surgery, organ transplants, durable medical equipment, medical supplies, prosthetics, orthotics, and out-of-Plan services. TPMG practitioners and TPMG-contracted practitioners are the ultimate authority for all other treatment decisions.

- TPMG provides onsite hospital case managers who work with the treating physician to manage the discharge and the enrollee's transition to outpatient services.

- The Plan evaluates the medical necessity of non-Plan emergent/urgent in-area services and arranges for repatriation to Plan providers when the enrollee is clinically stable and safe to transport. The Emergency Prospective Repatriation Program (EPRP) is the service that is the point of contact for all in-area non-Plan providers to contact and access for assistance with enrollee transfer.

- For non-Plan emergent/urgent services provided out of area, the Plan provides a similar service called Out-of-Service-Area Psychiatry (OSP). OSP conducts concurrent review for inpatients who are out of area. OSP also arranges for enrollee repatriation when the enrollee is clinically stable and safe for transfer. The claims department conducts retrospective claims for any services rendered by non-Plan providers and practitioners.

CONTINUITY AND COORDINATION OF CARE

- TPMG fosters continuity and coordination of behavioral health care through the following mechanisms:

  - All outpatient providers use a common psychiatric medical record that documents the date of visit, chief complaint, patient history, diagnostic information, treatment recommendations (including medication), and scheduled appointments.

  - Inpatient providers are required to send a copy of the discharge summary to the outpatient provider within two days of discharge. They are also required to send a more detailed discharge note within two weeks of discharge.

  - Integrated Urgent Services (IUS) is the program that coordinates care between inpatient and outpatient services. Programs to coordinate mental health services with chemical dependency, medical programs, and disease management are also available.

  - In addition to specialty case management programs associated with autistic children and persons with eating disorders, the TPMG has an Individual Case Management Program that focuses on the seriously and persistently mentally ill.

  - Typically, case management responsibility for a patient is vested in a single person also a primary therapist for that patient. The case manager is a member of a multidisciplinary treatment team, members of which are in close physical proximity to one another and who document contacts, consultations, and interventions in a single medical record. These factors facilitate communication about patient care. Case managers report using multiple strategies for communicating, including telephone, e-mail, fax, person-to-person contact, and attendance at weekly team meetings.

- TPMG coordinates mental health and medical care information and services in the following ways:

  - Behavioral health clinicians working in primary care and selected specialty settings offer onsite consultation as well as immediate interventions.

  - Primary care and specialist physicians have access to on-call psychiatrists for consultation at any time.

  - The automated Clinical Information Presentation System (CIPS), accessible to PCPs as well as other physicians, contains information about behavioral health visits, provider information, and medications.

  - The e-consult system is the primary mechanism for requesting consultations from specialists, including psychiatry/behavioral health, and for providing feedback on those consults to the referring provider.

  - Emergency room personnel may call the behavioral health call center to access information about the enrollee's psychiatric care.

- The Department interviewed representatives of case management programs providing services to members with autism, members with eating disorders, and members needing intensive psychiatric case management. Case mangers were asked to describe cases and their roles in providing services as a member of a multidisciplinary team. Descriptions and subsequent discussions revealed a comprehensive, integrated case management process that is reliable and relatively seamless for the patient and family. Case managers:

  - Are active members of a treatment team having very broadly defined roles;

  - Provide direct services and support to patients and their families;

  - Consult with and refer to providers in other medical departments (e.g., family practice, pediatrics, and neurology);

  - Refer patients into disease management or high-risk programs;

  - Consult with and refer to allied health professionals such as nutritionists;
  - Work collaboratively with other mental health professionals within their teams;
  - Have knowledge of and maintain ongoing relationships with community resources to which they may refer patients and families; and
  - Advocate for and help patients and families negotiate systems and bureaucracies such as the schools and regional centers.

- TPMG has developed and disseminated guidelines for major depressive disorder and attention deficit hyperactivity disorder (ADHD) in children and adolescents.
- In 1999, TPMG began using the HEDIS antidepression medication management measures to monitor provider performance relative to the major depression guideline.
- In 2003–2004 TPMG also began monitoring adherence to two aspects of the practice guideline for ADHD:
  - Percent of members, ages 5 through 18, with a new diagnosis of ADHD and started on stimulant medication who had a follow-up visit within one month.
  - Percent of members, ages 13 through 18, with a new diagnosis of ADHD who were seen in Psychiatry.
- The Plan and TPMG make extensive use of data on providers, provider sites, service utilization, and diagnosis to ensure appropriateness in detection, referral, and treatment of behavioral health problems among users of primary and specialty care. The availability of such data and the Plan's capacity to analyze them with regard to a variety of dependent and independent variables constitutes a powerful tool to ensure appropriateness of service provision within the system.
- TPMG has created and disseminated a variety of practice guidelines and treatment recommendations over and above those mentioned above for depression and ADHD.
- The TPMG Psychiatry Department conducts an Annual Operational Survey and onsite audit intended to review and evaluate the psychiatry programs available across all facilities in the region and to determine whether the facilities are providing an appropriate scope and level of services.

DELEGATION MANAGEMENT

Not Applicable

SOUTHERN CALIFORNIA KAISER PERMANENTE

OVERVIEW OF PROGRAMS

ACCESS AND AVAILABILITY

- Enrollees can self-refer for mental health services in several ways:
  - Walk in or call in to any of the 11 Psychiatry Departments throughout Southern California. Appointments can be scheduled by phone, or for urgent situations each clinic has on-duty clinicians available to see patients who walk into the clinic.
  - Call the Behavioral Health Care (BHC) Help Line, which is available 24 hours a day, 7 days a week, 365 days per year, and talk to a licensed BHC Help Line counselor. The counselor can facilitate or (in a crisis) schedule an appointment with a Plan provider or arrange admission to inpatient for acute stabilization.
  - Present to the emergency department at any Plan facility.
- Other referral pathways include:
  - Referral for appointment or consultation by the patient's primary care physician or other Plan provider;
  - For medical inpatients, referral through a medical center Consultation and Liaison service; and
  - Referral by an external employee assistance program (EAP) through each Psychiatry Department's EAP liaison.
- The Plan provides health care services in the Southern California area through a system of 14 service areas.
  - In 12 of the 14 service areas that represent 99 percent of the enrollment, a Plan medical center has associated medical offices and clinics. Psychiatry services are organized into departments that cover an entire service area and that are responsible for mental health services provided at one or more sites in the service area. Each department has a chief of service and an administrative manager.
  - KFH owns and operates one inpatient psychiatric facility in central Los Angeles. KFH contracts with 20 inpatient psychiatric facilities that serve adults and 17 inpatient facilities that serve children and adolescents.
  - In the remaining two service areas, the Plan contracts with the Delegates: Buenaventura Medical Group and Seaview IPA in Western Ventura County and Desert Medical Group and Oasis IPA in the Coachella Valley. The Plan is responsible for network development and maintenance, including monitoring the adequacy of the network. The Delegates are accountable for monitoring appointment availability. Heritage Provider Network, which operates Desert Medical Group and

Oasis IPA, is also accountable for providing triage and referral, whereas the Plan retains this function in relation to the Buenaventura Medical Group.

- Crisis services are provided by all of the KFH emergency departments and through the 24-hour BHC Help Line. Each emergency department has mental health staff on call 24 hours a day, 7 days a week for consultation and assistance with stabilizing the crisis.

  - During normal business hours, each BHC outpatient clinic has an on-duty clinician to handle crisis walk-in clients.

  - Clients in crisis who call the Member Services line or the appointment scheduling lines are transferred to the BHC Helpline for crisis-oriented assistance, with the Member Services staff person staying on the line until the BHC Help Line person answers.

  - In San Diego County, the Plan contracts with several short-term residential crisis intervention programs that provide stabilization and short-term treatment until the enrollee can be transferred to an appropriate inpatient or outpatient treatment setting.

  - The Plan and SCPMG are currently developing a Psychiatry Emergency Team (PET) to operate in Orange County. The PET, staffed by masters and doctoral-level clinicians, would respond to requests from facilities to evaluate Kaiser enrollees in crisis and arrange for appropriate care.

- The Plan directs patients who qualify for an involuntary admission (5150) to one of the 17 adult inpatient units or 12 child/adolescent inpatient units in the region contracted with KFH and that accept involuntary patients. Lanterman-Petris-Short-designated clinicians in all of the Plan service areas can assist in making involuntary admission determinations for enrollees in KFH facilities. Enrollees placed on an involuntary hold and detained in a non-KFH facility are repatriated to the Plan with assistance from the BHC Helpline.

- Each service area has a designated care manager for enrollees diagnosed with eating disorders and a designated care manager for enrollees diagnosed with autism. These care managers are master's-prepared licensed clinicians who serve as the enrollee's/family's primary therapist. They also coordinate care with outside providers and community-based organizations such as Regional Centers and school systems that may provide supplemental services.

UTILIZATION MANAGEMENT/ BENEFIT COVERAGE

- SCPMG physicians and physicians with whom SCPMG contracts for the provision of services are the ultimate authority in making decisions about whether a covered service is medically necessary. The exceptions are solid organ transplants, durable medical equipment, prosthetics and orthotics, home health care, bariatric surgery, and services provided by noncontracted providers, for which SCPMG requires prior authorization, and in the case of inpatient services in noncontracted facilities, concurrent review.

- SCPMG provides physician advisors to assist practitioners in making decisions regarding service requests for all services provided within the Plan's delivery system. The role of the physician advisor is to assist the ordering/attending physician in making service decisions, not to approve or deny the ordering/attending physician's decision. Consequently, there are very few medical necessity denials for in-plan services.

- Most denials are related to out-of-network inpatient admissions in which the enrollee refuses repatriation to a Plan facility when safe transport is possible.

- SCPMG has developed UM criteria consistent with InterQual ISD Criteria for inpatient and partial hospitalization services, including outpatient and intensive outpatient services.

- The Plan provides comprehensive evaluative services for children with autism and pervasive developmental delay (PDD). Each of the 12 medical centers has a dedicated autism case manager responsible for the coordination of services within the Plan and outside of the Plan as necessary for children with autism and PDD. When possible, the Plan complements services provided by the involved regional centers and school systems.

CONTINUITY AND COORDINATION OF CARE

- SCPMG provides continuity and coordination of care within the behavioral health system in the following ways:
  - Each member receiving psychiatric services has a single psychiatric case record available to all members of the patient's treatment team. In addition, selected information about the patient's treatment is available in the centralized medical information system.

  - Information about mental health admissions is entered into a behavioral health tracking system within 48 hours of admission.

  - Inpatient providers are required to complete and fax final inpatient progress notes and discharge summaries to the follow-up outpatient provider within 72 hours of discharge.

- SCPMG provides continuity and coordination of care between mental health providers and medical providers as follows:

  - The primary mechanism of exchange between mental health and medical providers is the Primary Care Information Sharing (PCIS) form forwarded to the primary care physician (PCP) and placed in the patient's medical record. It is completed at intake, when a case is reopened, upon a significant change in the treatment plan, and annually for patients in ongoing treatment.

  - Selected information on mental health diagnosis and treatment is available to all providers in the centralized automated information system. Mental health

professionals have access to pharmacy, lab, and diagnostic information related to medical services in this same system.

- Primary care and specialist physicians have access to on-call psychiatrists for consultation at any time. In addition, medical office buildings have onsite mental health professionals in the primary care setting who can provide direct consultation on behavioral health issues and direct therapy to enrollees.

- The Department did not review actual case management files because such files do not exist as distinct entities. Case managers, all of whom are master's-prepared clinicians, are part of the treatment team and document contacts in the patient's medical record. In lieu of file review, the Department interviewed three case managers, providing services to enrollees with autism, enrollees with eating disorders, and enrollees needing intensive psychiatric case management. These interviews revealed a comprehensive, integrated case management process that is reliable and relatively seamless for the enrollee and family.

- Case managers:

  - Are active members of the enrollee's treatment team;

  - May provide direct therapy services and support to enrollees and their families;

  - Consult with and refer to providers in other medical departments (e.g., family practice, pediatrics, and neurology);

  - Refer enrollees into medical disease management or medical high-risk programs;

  - Consult with and refer to allied health professionals (e.g., nutritionists and speech and language therapists);

  - Know and maintain ongoing relationships with community resources to which they may refer enrollees and families;

  - Advocate and help enrollees and families negotiate systems and bureaucracies, such as the schools, regional centers, the Social Security Administration, and the Department of Rehabilitation.

- SCPMG handles transitions of care in the following manner:

  - New enrollees who meet the criteria for continuing services for an acute or chronic condition from a non-Plan provider are allowed to continue with that provider for the duration of the condition for acute conditions and for up to 12 months for a serious chronic condition. During this period the Department of Psychiatry assigns the enrollee to a participating provider within the department who is responsible for communicating with the nonparticipating provider about the enrollee.

  - To facilitate the actual transfer, the participating provider obtains a release of information from the enrollee and requests the enrollee's record from the nonparticipating provider.

  - This procedure applies also to enrollees in treatment with a terminating Plan provider.

- SCPMG has adopted and implemented a clinical practice guideline for the treatment of major depression in the primary care setting that includes criteria for when the enrollee should be referred to mental health. The SCPMG monitors primary care practitioner and mental health practitioner performance against the depression treatment guidelines through the HEDIS depression measures. The Plan's performance was above the 90th percentile threshold (HEDIS) for the three indicators the last two reporting years.

- SCPMG has implemented depression screening and referrals protocols in the following areas:

  - Post myocardial infarction depression screening
  - Cardiovascular disease and asthma registries
  - Geriatric care management
  - Chronic care clinics; e.g., heart failure, diabetes
  - Postpartum care

DELEGATION MANAGEMENT

The delegation agreement between SCPMG and the Delegates and its successors and amendments reference the EOC, which clearly defines parity diagnoses and benefits related to parity diagnoses. Delegates agree to provide benefits as described in the EOC.

A P P E N D I X C

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the onsite survey at the Plan's northern regional administrative office during May 16–19, 2005, and the Plan's southern regional administrative office during May 2–5, 2005.

KAISER FOUNDATION HEALTH PLAN, INC.	
Name	**Title**
Kurt Drumheller	Director, Member Relations, Health Plan Regulatory Services
Wendy Magnacca	Senior Claims Operations Leader, Southern California Claims Administration
Susan Magee	Managing Director, Regulatory Response, Health Plan Regulatory Services
Steve Gray, PharmD	California Pharmacy Professional Affairs Leader
Kay Simmons-Gilpatric	Director, Network Quality
Martha Sikkens	Director, Survey Readiness, Health Plan Regulatory Services
Vicki George	Vice President, Quality
Marilyn Ammons	Director, Member Relations, Health Plan Regulatory Services
Vicki Stanley	Assistant Director Member Relations, Health Plan Regulatory Services
Sheila Tucker	Director, Clinical Review California Claims Administration
Katherine Vanderveen	Senior Leader, Operational Support and Planning, California Claims Administration
Linda Fearon	Manager of Quality Assurance, Training and Exception Processing, California Claims Administration

THE PERMANENTE MEDICAL GROUP	
Name	**Title**
Robert Klein, MD	Associate Executive Medical Director
Robin Dea, MD	Chair, Chiefs of Psychiatry
Stuart Buttlaire, PhD, MBA	Regional Director of Inpatient Psychiatry/Utilization
Sonya Struc	Senior Managerial Consultant, Quality and Operations Support
Nan Shaw, LCSW	Easting Disorder Champion, Department of Medicine, Oakland
Malcolm Gordon, MD	Primary Care, Santa Teresa, Chief, Department of Medicine, Liaison to Behavioral Health Group
Rick Smith, MD	Chair, Chiefs of Continuing Care, Medical Director, Kaiser Permanente Post-Acute Care Center
Pilar Bernal, MD	Chair of Chiefs of Child Psychiatry
Mark McCormick, MD	Chief of Psychiatry, Santa Clara, Chair Behavioral Health Quality Improvement Committee
Melissa Brint, RN	Utilization Management Compliance Director, KFH

THE SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP	
Name	**Title**
John Brookey, MD	Assistant Medical Director of Quality
Dennis Cook, MD	Regional Chief of Psychiatry, Chief of Service, Psychiatry and Addiction Medicine, San Diego
Scott Sangsland, MA	Regional Director of Behavioral Health Care Services
Mary Gibbons	Manager, Medical Audit
Susan Bassett, LCSW	Autism Case Manager, San Fernando Valley Service Team
Martha Shenkenberg	Regional Depression Consultant
Marguerite Koster	Director, Clinical Analysis, Clinical Practice Guidelines Unit
Mark Dreskin, MD	Family Practice, Baldwin Park
Stan Cias, MSN	Southern California Regional Director of Utilization Management
Maureen Clarke, LCSW	Manager, Behavioral Health Crisis Line

THE SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP *(Continued)*	
Name	**Title**
Catherine Berman	Director, Professional Contracts and Network Management
Brenda Scott Meade	Case Manager, Eating Disorders
Sarah Schaefer	Intensive Case Manager
Irving Osowsky, MD	Child Psychiatrist, Chief, Psychiatry, Panorama City and Woodland Hills
Marcia Kagnoff, PhD	Administrator, Department of Psychiatry, San Diego

A P P E N D I X D

LIST OF SURVEYORS

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	**Title**
Tom Gilevich	Counsel, HMO Help Center

MANAGED HEALTHCARE UNLIMITED, INC., REPRESENTATIVES	
Name	**Title**
Rose Leidl, RN, BSN	Contract Manager, both regions
Bernice Young	Program Director, both regions
Ruth Martin, MPH, MBA	Parity Survey Team Leader, both regions
Sharon Shueman, PhD	Continuity and Coordinator of Care Surveyor, both regions
Erick Davis, MD, MPH, MBA	Utilization Management Surveyor, both regions
Patricia Allen, MEd	Access and Availability Surveyor, north region
Nikki Cavalier, LCSW, CPHQ	Access and Availability Surveyor, south region
Linda Woodall	Emergency Room Claims Surveyor, both regions

A P P E N D I X E

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCES—NORTHERN CALIFORNIA KAISER PERMANENTE

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan does not ensure that enrollees have timely access and ready referral to routine mental health services appointments for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code Section 1374.72. [Rule 1300.74.72(f) and Rule 1300.67.2(f)]

Citations:
Rule 1300.74.72(f)
A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72…

Rule 1300.67.2(f)
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments…

B. UTILIZATION MANAGEMENT

Deficiency 2: The Plan does not consistently provide the name and direct phone number of the denying health care professional in the denial letter sent to the requesting mental health professional. [Section 1367.01(h)(4)]

Citation:
Section 1367.01(h)(4)
…Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification….

Deficiency 3: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4 (b) and (c)]

Citation:

Section 1371.4 (b) and (c)
(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCES—SOUTHERN CALIFORNIA KAISER PERMANENTE

A. UTILIZATION MANAGEMENT

Deficiency 1: The Plan does not clearly and concisely describe the clinical reasons and clinical criteria used in making medical necessity denial determinations in the denial letters sent to enrollees and providers. [Section 1367.01(h)(4)]

Citation:
Section 1367.01(h)(4)

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, … and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity.

Deficiency 2: In its benefit denial notifications, the Plan does not provide the provisions of the Evidence of Coverage (EOC) or benefit contract that excludes the coverage. [Section 1368(a)(5)]

Citation
Section 1368(a)(5)

…If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Deficiency 3: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4 (b) and (c)]

Citation
See citations for northern California

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
ADHD	Attention Deficit-Hyperactivity Disorder
BHC	Behavioral Health Center
BMG	Buenaventura Medical Group
CAP	Corrective Action Plan
CD	Chemical Dependency
CIPS	Clinical Information Presentation System
DMH	Department of Mental Health
DOI	Department of Insurance
EAP	Employee Assistance Program
EDIOP	Eating Disorder Intensive Outpatient Program
EOC	Evidence of Coverage
EPRP	Emergency Prospective Repatriation Program
ER	Emergency Room
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases 9th Revision Clinical Modification
ICE	Industry Collaborative Effort
IMR	Independent Medical Review
IPA	Individual Practice Association
IUS	Integrated Urgent Services
KFH	Kaiser Foundation Hospitals
KFHP	Kaiser Foundation Health Plan, Inc.
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LVN	Licensed Vocational Nurse
MCAT	Medical Center Administrative Team

Acronyms	Definition
MH	Mental Health
MSA	Metropolitan Statistical Area
NCKP	Northern California Kaiser Permanente
OSP	Out-of-Service Area Psychiatry
PACC	Psychiatry After-Hours Call Center
PCP	Primary Care Physician
PDD	Pervasive Developmental Delay
PET	Psychiatry Emergency Team
PMG	Primary Medical Group
RN	Registered Nurse
SCKP	Southern California Kaiser Permanente
SBHC	Stanislaus County Department of Behavioral Health and Recovery Services
SCPMG	Southern California Permanente Medical Group
SPN	Stanislaus Provider Network
TPMG	The Permanente Medical Group
UM	Utilization Management

A P P E N D I X G

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which the Department undertakes them as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. Table 18 summarizes the survey activities and the corresponding timeframes.

TABLE 18: FOCUSED SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Focused Survey OnSite Visit Conducted	As needed
Preliminary Report due from the Department to the Plan	30 –50 calendar days from the last day of the onsite visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Focused Survey Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the onsite visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the onsite visit

Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an adhoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-Onsite Visit Questionnaire and a list of required materials such as Plan operations, policies, and procedures. The Department reviews these to prepare for the visit, and also advises the Plan that the survey team will review case files and reports during the onsite visit so that they will be readily available.

Onsite Visit

During the onsite visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the onsite visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, they include only specific areas found by the Department to be in need of improvement. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department, and in its 45-day response must submit evidence that the required actions have been or are being implemented.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response, and if so, evidence that documents the corrected deficiencies;

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is moving toward compliance, a timeline for implementing the corrective action, and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's Web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the Web portal. The Plan *is not* to submit its entire response to the Preliminary Report through the Department's Web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response, and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the onsite survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.